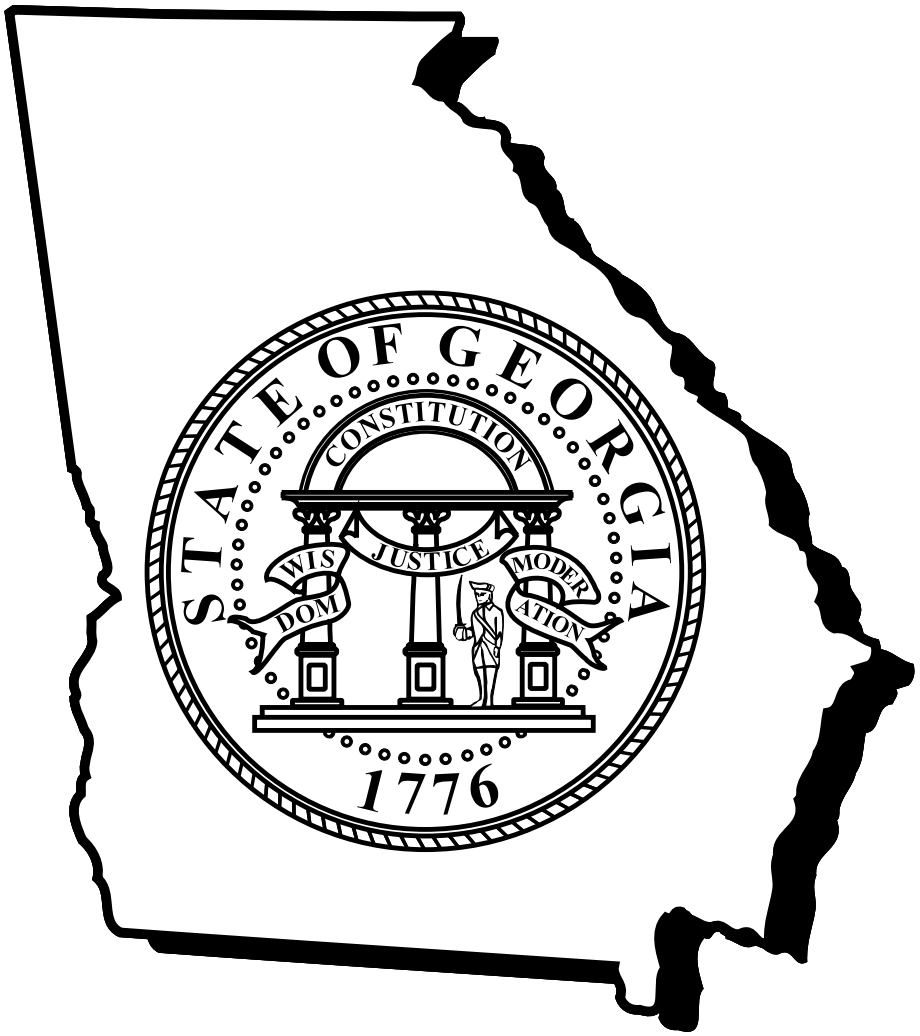
GEORGIA'S STATEWIDE CHILD ABUSE PREVENTION PANEL

Annual Report
Calendar Year 1999



J. TOM MORGAN CHAIRPERSON • ROY E. BARNES, GOVERNOR

December 1, 2000

GEORGIA'S STATEWIDE CHILD ABUSE PREVENTION PANEL

Annual Report
Calendar Year 1999

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GEORGIA STATEWIDE CHILD ABUSE PREVENTION PANEL

MISSION

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatalities, establishing and ensuring proper procedures for the handling of child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

ACKNOWLEDGEMENTS

The Statewide Child Abuse Prevention Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible. These include:

John T. Carter, Ph.D., and associates (Emory University)
Members of Child Fatality Review Teams across the State

GEORGIA STATEWIDE CHILD ABUSE PREVENTION PANEL

MEMBERS

Chairperson
J. Tom Morgan
District Attorney, Stone Mountain Judicial Circuit

Vacant.
Medical Examiner

Honorable Cynthia Wright
Judge, Fulton County Superior Court

Vacant
State Senator [1]

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Director, Department of Family and Children Services [3]

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Cobb County Police Department

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Cyler Garner, M.D.
Chair, Board of Human Resources [3]

Mr. Milton E. "Buddy" Nix, Jr.
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Judge, Cobb County Juvenile Court

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Advocate, Injury Prevention

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Chair, Criminal Justice Coordinating Council

Randell Alexander, M.D.
Advocate, Child Abuse Prevention

Ms. Vanita Hullander
Coroner, Catoosa County

STAFF

Eva Y. Pattillo, *Executive Director* **Karen Robinson**, *Administrative Assistant*

The Statewide Child Abuse Prevention Panel is an appointed body of 15 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two-year appointments are made by the governor except as otherwise noted.

1 Appointed by the Lieutenant Governor
2 Appointed by the Speaker of the House of Representatives
3 Ex-Officio

MESSAGE FROM THE CHAIR

On behalf of the Statewide Child Abuse Prevention Panel, I am pleased to present the 2000 Annual Report. This report represents countless hours of work by volunteers all across the state who review child deaths in their communities. This is not pleasant work, but necessary work for the future well being of children in Georgia.

Reports from child fatality review committees indicated an increase in the number of child abuse and neglect related deaths which is of special concern to the Panel. Our hope is that this increase represents better identification and reporting by child fatality review committees and child death investigation teams, and does not reflect an actual increase in the number of deaths resulting from abuse or neglect. The media has continued to focus on systemic problems believed to contribute to the deaths of children. Responses to these alleged problems have included:

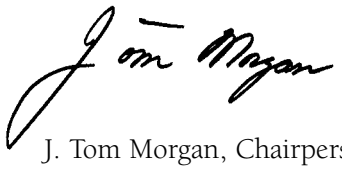
- an order by the governor for an investigation by the Georgia Bureau of Investigation (GBI) into particular deaths of children known to the Department of Family and Children Services (DFCS), and
- the formation of a task force by the Commissioner of the Department of Human Resources to review the polices and practices of child protective services in the state, and to make recommendations regarding needed changes

The results of the investigation by the GBI pointed out numerous policy violations as well as the need for major restructuring within DFCS. These recommendations, as well as others, were reiterated by the Task Force and are supported by the Statewide Child Abuse Prevention Panel.

The Panel, in collaboration with GBI and DFCS, has continued to expand child death investigation teams across the state. These teams offer more accurate identification of the causes and circumstances of child deaths in Georgia.

Georgia is still the only state without a Child Endangerment Statute. Such a statute will hold adults accountable who knowingly create dangerous situations, or allow children to be placed in dangerous circumstances that risk harm, or actually harm a child. The Panel strongly urges the Georgia legislature to pass a Child Endangerment Statute during the next session.

It is our belief that with more accurate information and the implementation of recommendations by the Task Force, GBI, and the Panel, Georgia will be well on its way to better protecting children.



J. Tom Morgan, Chairperson
Statewide Child Abuse Prevention Panel

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Childhood is a time of life when safety and protection are paramount to well being. Georgia is considered one of the best places in the country to do business; however, "our state remains one of the worst places in the United States for a child to live" (Georgia Kids Count Factbook 1998-1999). Three of the 10 indicators used by Kids Count to determine well being of children are mortality rates for infants, children, and teens. Though these indicators showed improvement between 1992 and 1997, we continue to lag behind much of the nation.

In 1999, Vital Records' preliminary file indicated that 1,704 death certificates were issued for children ages birth - 17 who were residents of Georgia. Sixty-one percent (1037) of these deaths occurred in infants with the vast majority (95%) a result of natural causes. The majority (61%) of deaths in children ages 1 – 17 was injury related. The leading causes of injury related death included motor vehicle crashes (225), homicide (68), drowning (53), suffocation (34), and suicide (26). Firearms were used in 51 deaths from injuries. SIDS (sudden infant death syndrome) accounted for an additional 116 deaths (8 of which listed SIDS on the death certificate, but not as the primary cause of death).

During the past year, much of the news media in Georgia has focused on children whose deaths were related to child abuse and/or neglect, and thought to be both preventable and predictable. The implication made by the media was that the involvement of public agencies in the lives of children failed to prevent their deaths. This report addresses the issue of deaths related to abuse and neglect.

Child fatality review committees in Georgia are charged with reviewing the deaths of all children when those deaths are suspicious, unexpected, or unexplained ("eligible deaths"). As part of the review process, particular emphasis has been placed on determining whether deaths were preventable, and if preventable, what actions should be taken to prevent similar deaths in the future.

Child fatality review committees reported a notable increase in the number of child abuse/neglect related deaths. Reports identified the following:

- A total of 114 deaths were suspected (52) or confirmed (62) child abuse and/or neglect.
- Child abuse and/or neglect related homicides (44) made up more than one half of all reviewed homicides (74).
- Firearms were used in 11 of these child abuse and/or neglect related homicides.
- Perpetrators in 51% of child abuse cases were parents.
- Ninety-one percent of child abuse and/or neglect related deaths were determined to be definitely or possibly preventable.
- In 84 (74%) child abuse or neglect related deaths, the family had prior involvement with a state or local agency.
- Agency intervention was determined inadequate in 20 cases (24%), and it was determined that agency intervention could have prevented 10 deaths.

Child fatality review committees reviewed 437 (76%) of these "eligible" deaths, and an additional 135 deaths for a total of 572 deaths reviewed. This represents a 10% increase over the number of deaths reviewed for 1998, and is the largest number of reports submitted since the inception of the child fatality review process in 1990.

This Annual Report contains detailed information from reports submitted by county child fatality review committees. The Statewide Child Abuse Prevention Panel is charged with not only tracking the numbers and causes of child death, but also identifying and recommending prevention strategies that could reduce the number of children who are deprived of their childhood. Children can be better safeguarded if the valuable information in this report is used by the readers to encourage implementation of the Panel's recommendations. A summary of these recommendations to the governor and general assembly are listed below.

RECOMMENDATIONS OF THE GEORGIA CHILD ABUSE PREVENTION PANEL

1. Funding should be provided for:
   - annual training for child fatality review team members
   - stipends for overburdened review teams to help ensure that they meet the defined review standards
   - sufficient staffing and resources for the Panel to carry out its mandated responsibilities
   - expanding the dissemination of the Panel's annual report
2. Georgia legislature should pass a "Child Endangerment Law" to hold adults accountable who knowingly create or allow children to be placed in dangerous situations
3. A pediatric forensic pathologist "in-training" position via the GBI Forensic Pathologist Fellowship Program should be funded to assist in developing qualified pathologists to perform child autopsies
4. The Teenage and Adult Driver Responsibility Act should be further strengthened to preclude drivers under the age of 17 from operating a motor vehicle:
   - on public roads between the hours of 10:00 p.m. and 6:00 a.m.
   - with more than one passenger in the vehicle less than 21 years of age
5. Expand home-based family support models that show promise for preventing child abuse and neglect
6. Implement recommendations of the Child Protective Service Task Force to improve the State's ability to protect children from child abuse and neglect
7. Amend the current seat belt law to require that children 3 – 5 years old be transported in a booster seat
8. Require fences and gates in public and private swimming pools statewide
9. An annual hearing should be held by appropriate committees of the General Assembly (including the Judiciary Committees) to receive the Panel's report to the governor

LIST OF FIGURES AND TABLES

CHILD DEATHS IN GEORGIA

Each year in Georgia hundreds of children die before they reach the age of 18. A majority of these children die before their first birthdays. In 1999, 1,704 children died, which was equivalent to almost five children dying every day. Unfortunately, these deaths represent only a small percentage of serious injuries to children. Many children suffer preventable non-fatal injuries that result in disabling conditions. These non-fatal injuries impose tremendous emotional, social and economic costs for families, communities and the state. The purpose of the child fatality review process is to analyze the circumstances of child deaths. This process is critical in identifying prevention strategies that can help reduce these needless costs and improve the health and well being of Georgia's future generations.

• Information Sources

The child fatality review reports are the primary source of data for this report. Child fatality review reports are submitted on deaths that are identified by the county coroner, medical examiner, or child fatality review committee. In addition to the SIDS and accidental/violent deaths, the committee may identify other deaths as appropriate for review. Child fatality review reports provide details of the cause and circumstance of death, supervision at time of death, prior history of abuse or neglect, perpetrator(s) in child abuse-related deaths, and prior agency involvement. Reports also contain information about whether the death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

A preliminary 1999 death certificate file was used to describe all child deaths; therefore, the numbers for infant and child deaths in Table A.1 may vary slightly from the final Georgia 1999 vital statistics data. The death certificate file was also used to identify the subset of deaths that met the criteria for review. The child fatality review file was linked with the death certificate file. The death certificate provides demographic information and states the official cause of death. These two data sources do not always agree on the cause or manner of death. A child fatality review committee may determine the cause or manner of death for a child to be different from the reported cause or manner on the death certificate based on additional information made available to the committee.

Of the 1,704 child death certificates filed in 1999, 573 met the criteria requiring review. Child fatality review committees reviewed 437 (76%) of these eligible deaths, in addition to deaths related to medical causes that were unexpected, and 10 deaths for which no death certificate was issued. A total of 572 deaths was reviewed and are included in Appendix C.2 of this report.

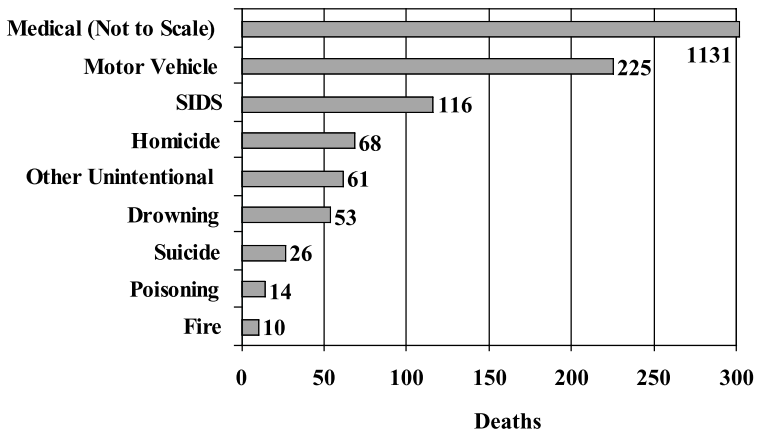
Throughout this report, information and figures from child fatality review reports are designated by the term "Reviewed Deaths", and include a total of 456 child deaths (injury-related and SIDS).

SUMMARY OF ALL DEATHS

Figure 1 shows the causes of all 1,704 child deaths in Georgia in 1999. Natural causes were responsible for 73% (1,247) of all deaths, with 79% (989) of these deaths occurring before age one.

The term "medical" when used in this report as a cause of death for infants does not include SIDS.

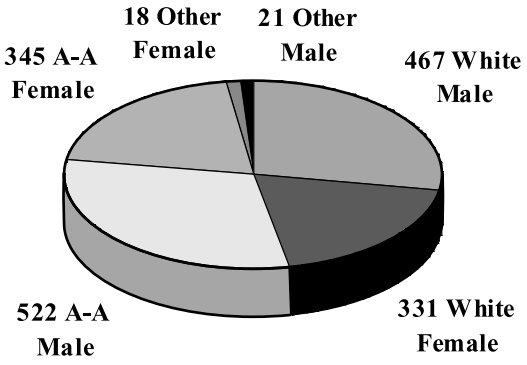
Figure 1. Deaths to Children Under 18 in Georgia: All Causes based on Death certificate



• Findings

- The total number of infant and child deaths (1,704) varied little from last year's total (1,706)
- Motor vehicle incidents continue to be the leading cause of injury related child deaths. In 1999 there was an (8%) increase from 209 deaths in 1998 to 225 deaths
- There was a substantial increase (36%) in drowning deaths compared to 1998 (39)
- Fire-related deaths dropped to the lowest number this decade

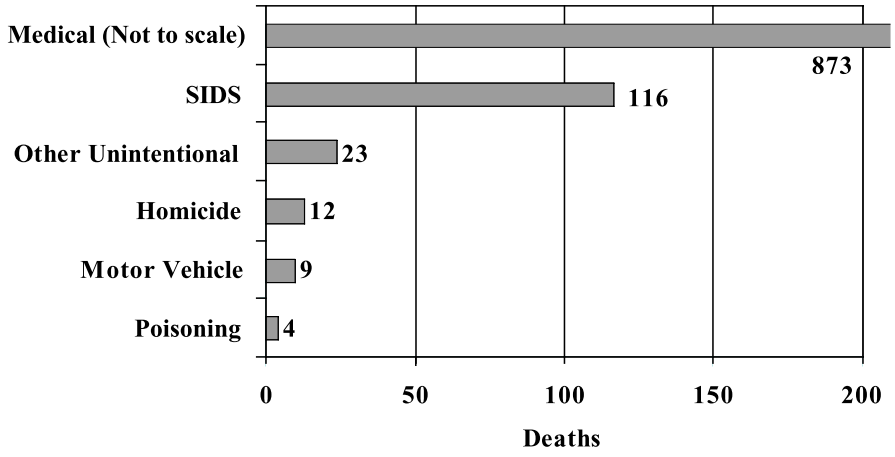
Figure 2. Race and Gender of All Child Deaths



• Finding

- Though African-American children make up only 34.3% of the child population, their deaths make up 51% of all child deaths

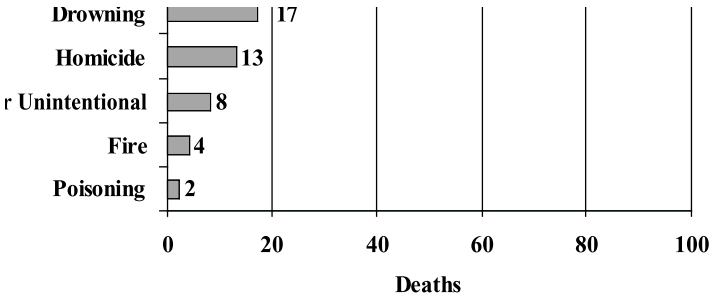
Figure 3. All Causes of Death, Age < 1



• Findings

- 95% of infant deaths resulted from natural causes (medical and SIDS)
- Of defined causes, suffocation was the largest single injury-related category.

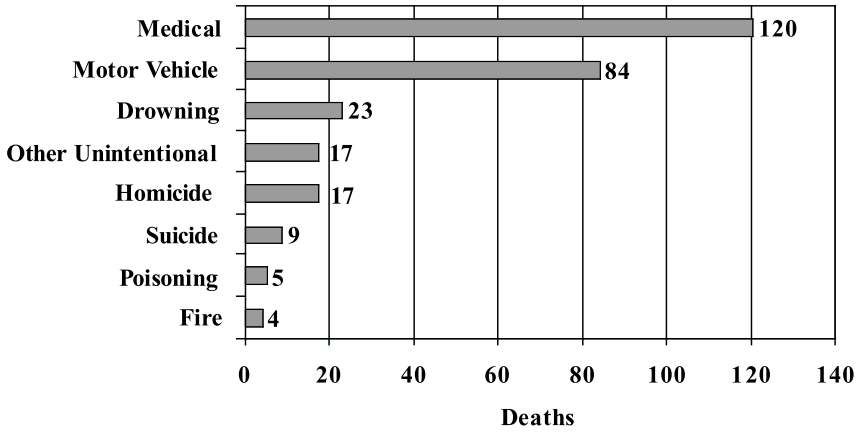
Figure 4. All Causes of Death, Age 1-4



• Findings

- Over half of deaths (52%) resulted from medical conditions
- 32% (17) of drowning deaths occurred in this age group which had the highest rate of drowning deaths for any age group (3.7 per 100,000)
- Motor vehicle incidents accounted for over half (52%) of unintentional deaths

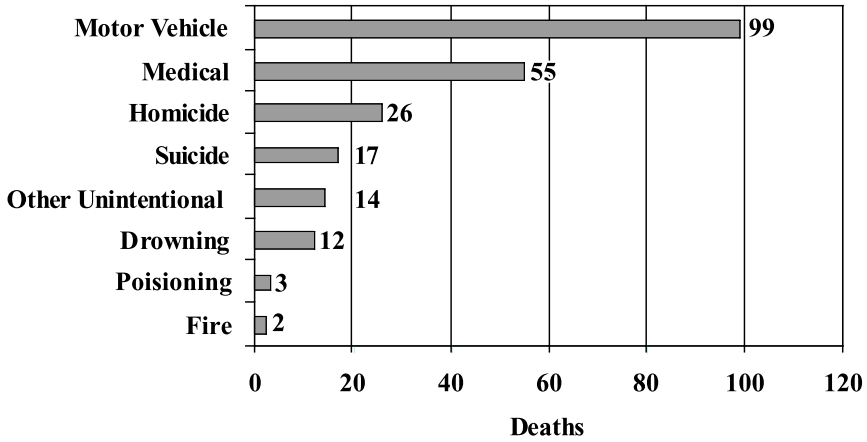
Figure 5. All Causes of Death, Age 5-14



• Findings

- 57% of deaths in this age group were caused by injury (intentional and unintentional)
- Increases were seen in both homicide (70%) and suicide (50%) compared to 1998

Figure 6. All Causes of Death, Ages 15-17

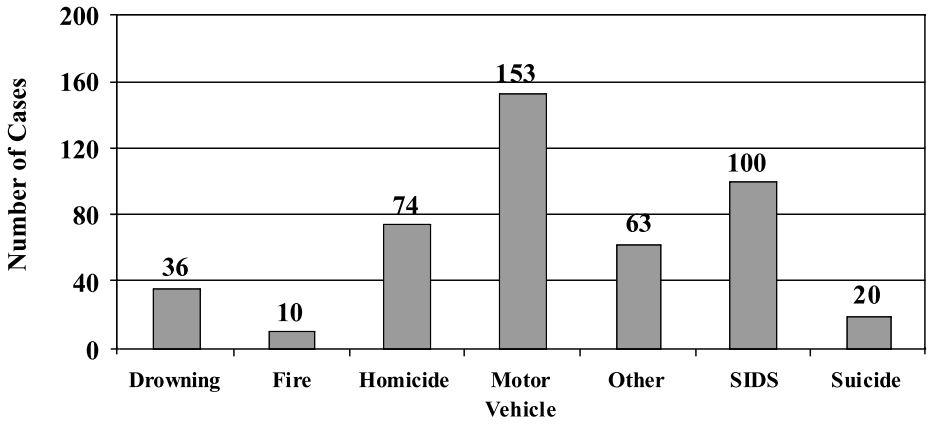


• Findings

- Motor vehicle incidents represented 43% of deaths
- 46% of all deaths from intentional incidents (homicide and suicide) occurred in this age group which is a decrease from 1998 (56%)
- Homicide deaths decreased 21% from 1998 (33 deaths)

In 1999, 573 of 1,704 child deaths met the criteria requiring review according to death certificate data. Committees reviewed 76% (437) of those deaths, which represents the largest percentage of eligible deaths reviewed since the inception of child fatality review in Georgia. (In 1998, 70% of deaths were reviewed). Committees reviewed an additional 135 deaths for a total of 572 deaths reviewed. Four hundred fifty-one (451) of 572 reviewed deaths are included in the "Reviewed Deaths" section of this report (injuries and SIDS).

Figure 7. Number of Reviewed Child Deaths by Cause of Death



• Finding

- One third of eligible deaths reviewed were motor vehicle related

Preventability

Each child fatality review report asks the team to determine if the death could have been prevented. Only 4% of reports omitted this information. Of the remaining 96% of reports addressing preventability, teams determined the following:

Definitely Preventable	**34%**
Possibly Preventable	**33%**
Not Preventable	**33%**

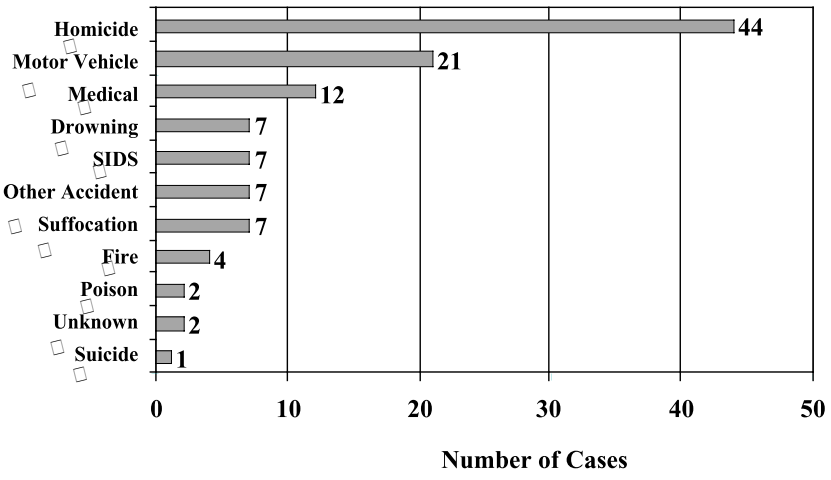
The prevention potential varied strongly by cause of death. No SIDS deaths were determined to be "definitely preventable", but 64% of the homicides were determined to be definitely preventable. Overall, 53% of the injury-related deaths were judged to be definitely preventable.

CHILD ABUSE AND NEGLECT

The child fatality review committees either suspected or confirmed child abuse or neglect in 114 (20%) of the 572 reviewed deaths. For 63 (55%) of these deaths, the abuse or neglect was confirmed. Twenty-nine deaths were due to neglect, and 34 were due to acts of violence (abuse). Appendix C.3 provides the data on maltreatment by age, gender and cause of death. The child fatality review committees did not always agree with the cause of death stated on the death certificate, resulting in small differences in numbers of abuse-related deaths in some categories. In this section, deaths are discussed using the committee's determination of cause of death.

Review committees determined that 63% (72) of deaths with abuse or neglect findings were definitely preventable (compared to only 26% of deaths without abuse or neglect findings). Of the remaining deaths related to child abuse or neglect, 28% (32) were possibly preventable, 8 deaths (7%), were not thought to have been preventable, and 2 deaths were missing this information.

Figure 8. Circumstances of Death for Reviewed Deaths with Abuse/Neglect Findings

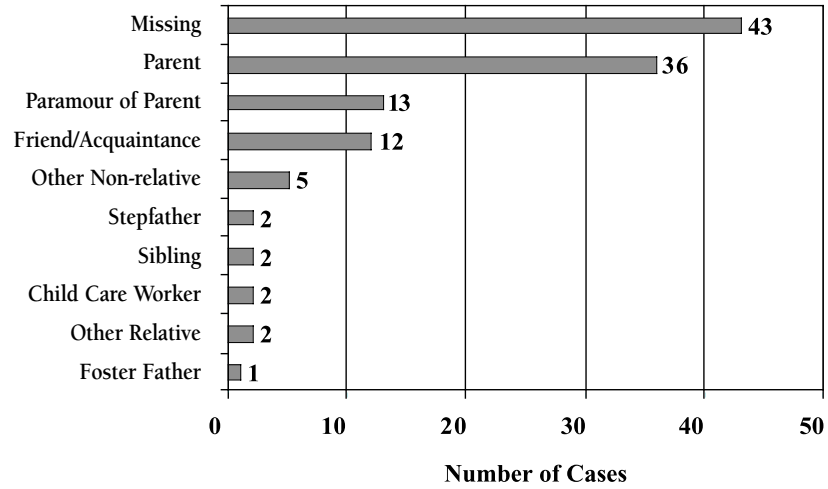


Findings

- 39% of child abuse/neglect related deaths were homicides
- Of the 44 homicides, 11 were due to firearm, 10 to being struck, 7 to neglect, 5 to Shaken Baby/Sudden Impact Syndrome, 3 to drowning, 3 to cut/stabbed, 2 to fire, 1 to suffocation, 1 to being thrown, and 1 to poisoning
- Other causes of child abuse and neglect deaths include uninten tional suffocation, unintentional firearm injury, unintentional poisoning, and suicide

Perpetrators

Figure 9. Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse and Neglect Findings

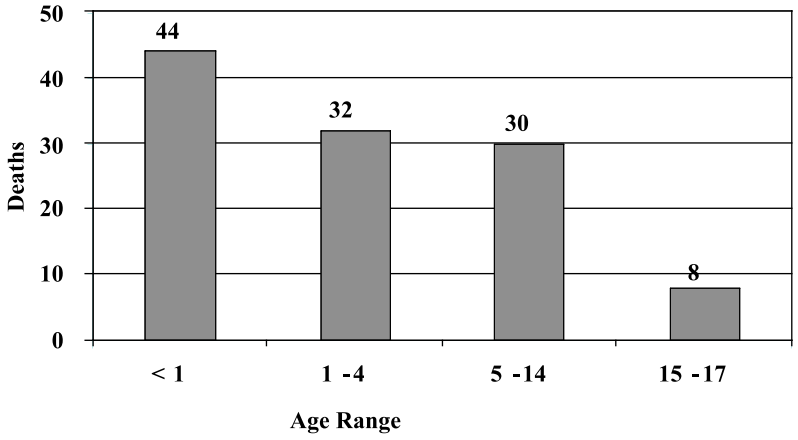


*Total = 118, reflecting 4 cases with 2 perpetrators identified.

Findings

- 75 perpetrators were identified in 71 of the 114 deaths (62%)
- Among the 75 identified perpetrators, 51% (38) were parents (natural and step), and 17% (13) were parents' male paramours

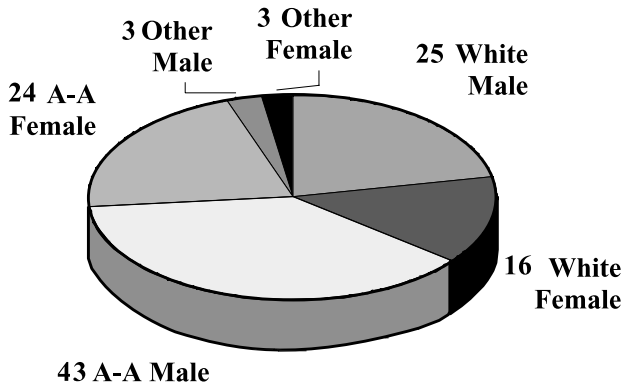
Figure 10. Age Distribution for Reviewed Deaths with Abuse or Neglect Findings



• Findings

- 67% were under the age of 5
- 39% were under the age of 1

Figure 11. Reviewed Deaths with Abuse or Neglect Findings by Race and Gender



• Findings

- 59% (67) of deaths were African-American children
- 62% (71) of deaths were males and 38% (43) deaths were African American males

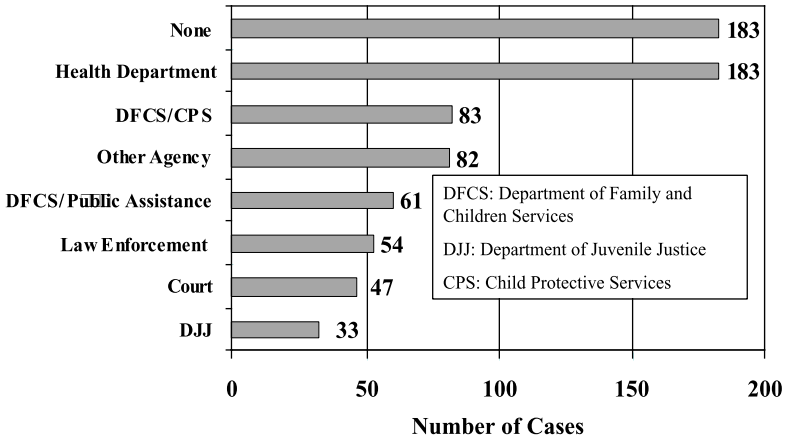
Opportunities for Prevention

- Promote child maltreatment as a community problem requiring implementation of prevention approaches within all sectors of the community
- Develop strategies to reach more children and families with prevention efforts
- Expand home-based family support program models that show promise for preventing abuse and neglect
- Encourage child abuse protocol committees and child fatality review committees to become more active in informing their communities about prevention service successes, gaps and needs

PRIOR AGENCY INVOLVEMENT

Sixty-three percent (359) of all reviewed child fatality reports indicated that one or more community agencies had prior interaction with the deceased child or his/her family. A designated list of agencies is provided on the reporting form, but committees may add "other" if necessary. Agencies were not necessarily actively involved with children or families at the time of the deaths. The following figures list the agencies and the number of deaths in which they were identified. A child or family was often involved with more than one agency; therefore, the number of agencies exceeds the number of deaths on both figures.

Figure 12. Agency Involvement: Reviewed Deaths with No Child Abuse/Neglect Findings*



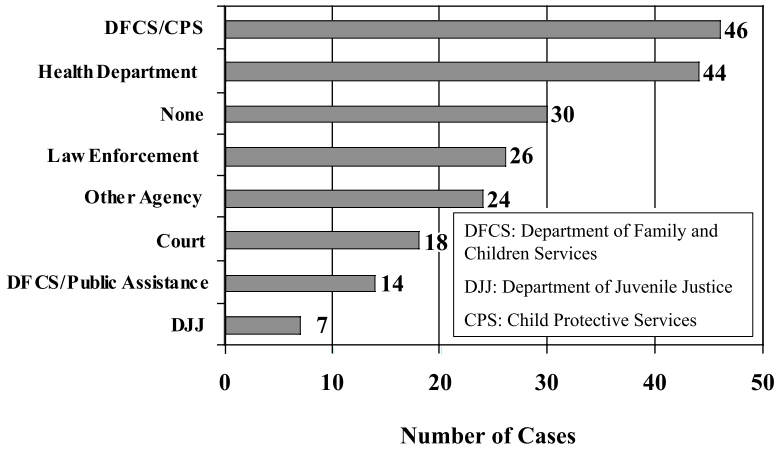
• Findings

- 60% of deaths (275) had prior agency involvement
- Families had involvement with an average of 2.0 agencies
- 40% of families had involvement with Public Health
- 31% of families had involvement with the Department of Family and Children Services

Figure 13. Agency Involvement: Reviewed Deaths With Child Abuse/Neglect Findings*

• Findings

- 74% of deaths (84) had prior agency involvement
- Families had involvement with an average of 2.1 agencies
- 39% of families had contact with Public Health
- 53% of child abuse/neglect deaths had prior contact with the Department of Family and Children Services
- For the 46 children/families known to Child Protective Services, 7 reports did not indicate the involve ment. For 39 children/families, involvement was indicated as follows:



*Total reflects more than one agency in some cases

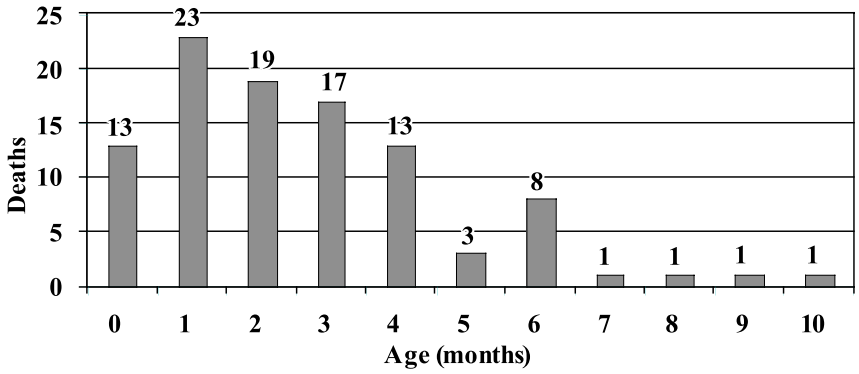
Decedent	12
Decedent and caretaker other than family	1
Both decedent and another child in the family	12
Another child in the family, not the decedent	10
Another child and caretaker other than family	2
Decedent, another child in family, and caretaker other than parent	2

SUDDEN INFANT DEATH SYNDROME

SIDS is the sudden death of an infant under 1 year of age that remains unexplained after the performance of an autopsy, examination of the death scene, and a review of the clinical history. In Georgia, SIDS is the leading cause of infant death among normal birth-weight infants from 1 month to 1 year of age. In 1999, death certificates listed 108 infant deaths as SIDS. An additional 8 deaths listed SIDS on the death certificate, but not as the primary cause of death. Child fatality review committees reviewed 100 deaths determined to be SIDS.

State law requires that an autopsy be completed for every SIDS death. Of the 100 deaths determined to be SIDS by child fatality review committees, 99 had autopsies completed, and 91 included a death scene investigation. These 9 deaths without death scene investigations should not have been determined to be "SIDS". The autopsy differentiates other medical conditions and injuries from SIDS, ensuring a more accurate count of SIDS deaths. Death scene investigation findings provide critical guidance for autopsies and should be completed before a SIDS death is determined. Because investigations are not conducted consistently throughout the state, there continues to be a statewide emphasis on the use of the sudden unexpected infant death investigation protocol. The use of this protocol should improve both the number of investigations and the quality of the information provided.

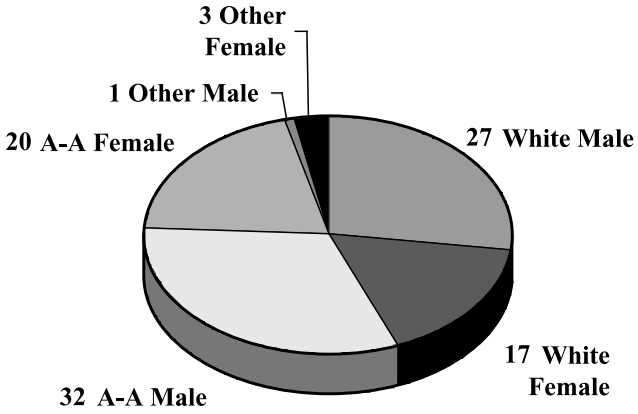
FIGURE 14. SIDS DEATHS BY AGE



• Finding

- 72% of SIDS deaths occurred among infants 0 to 3 months of age

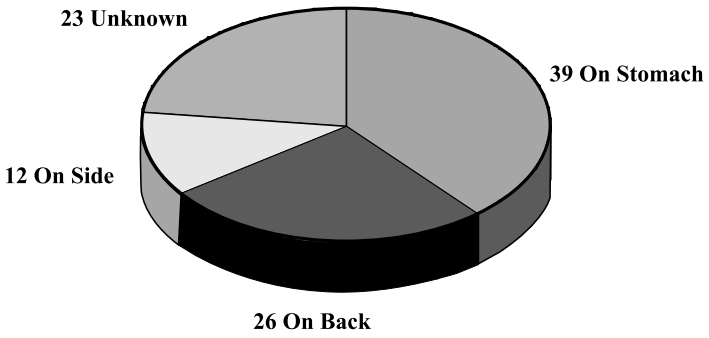
FIGURE 15. SIDS DEATHS BY RACE AND GENDER



• Findings

- 52% of SIDS victims were African-American, however, there were 1.4 deaths per 1,000 African-American births compared to 0.6 deaths per 1,000 white births
- 60% (60) of SIDS victims were male

Figure 16. Sleeping Position At the Time of Death for Infants Who Died of SIDS

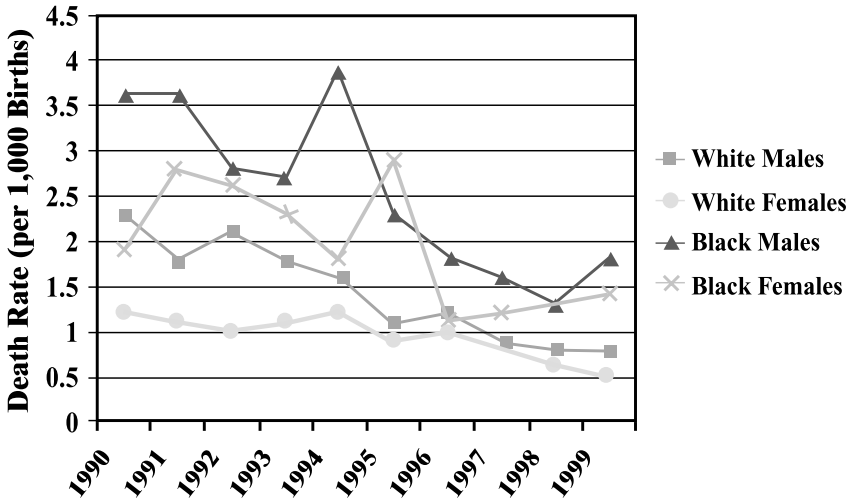


• Findings

- Sleeping position was known in 77% of SIDS deaths when the question about sleeping position was answered
- For SIDS deaths in which sleeping position was known, 51% of victims were reported to be sleeping on their stomachs and 34% on their backs

SIDS TRENDS

FIGURE 17. SIDS DEATH RATES PER 1,000, AGE <1, 1990-1999



• Findings

- The total number of SIDS deaths increased slightly to 116 in 1999 (from 109 in1998). However, there has been a striking decline in SIDS over the decade of the '90s. There was an average of 172 SIDS deaths per year from 1990 through 1994; the average has been 122 for the past five years. A portion of this decline is likely due to the "Back to Sleep" campaign
- The SIDS rates remain higher among black infants than among white infants, with black infants approximately twice as likely to be a victim of SIDS

Opportunities for Prevention

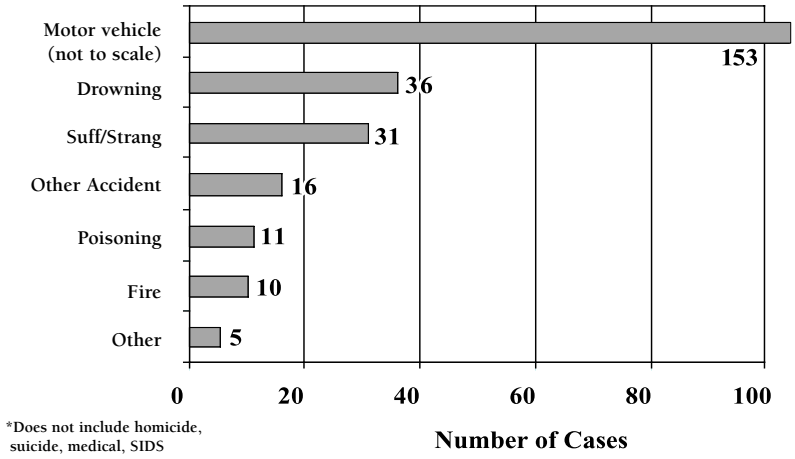
- Educate the public (targeting African-American communities) about risk reduction including back sleeping, breastfeeding, prenatal smoking cessation, smoke free environment and use of firm bedding materials
- Incorporate risk reduction information in prenatal education for expectant parents
- Promote completion of death scene investigations as a means to identify potential prevention opportunities

UNINTENTIONAL INJURY RELATED DEATHS

Child fatality review teams reviewed 356 deaths determined to be injury-related. Committees could not determine the cause of death for 5 of these children. Death certificate data indicated that injuries were responsible for 457 child deaths in 1999.

Of the 356 deaths determined to be injury related by child fatality review teams, 262 deaths were determined to be the result of unintentional injuries. Figure 18 shows the distribution of these unintentional injury-related deaths by type of injury.

Figure 18. Unintentional Injury-Related Deaths by Cause*



*Does not include homicide, suicide, medical, SIDS

• Findings

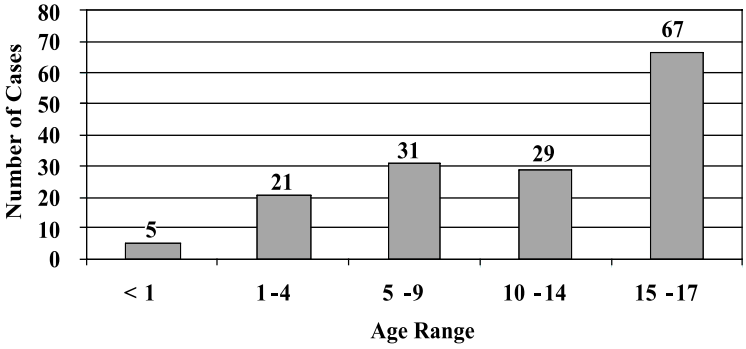
- 58% of deaths resulted from motor vehicle-related incidents
- 34% of injury-related deaths occurred among children under the age of 5
- Drowning deaths reviewed increased 13% from 1998 (32)
- Deaths caused by suffocation increased 48% from 1998 (21)
- Deaths due to poison increased 120% from 1998 (5)

MOTOR VEHICLE-RELATED DEATHS

Motor vehicle-related deaths were the leading cause of death among teens ages 15-17 and the second leading cause of death to children between ages 1 and 15 in Georgia. A total of 153 deaths reviewed by child fatality review committees were related to motor vehicle incidents. Death certificate data indicated a total of 225 deaths from motor vehicle incidents.

Of the 153 reviewed motor vehicle-related deaths, 48% (74) involved children who were passengers, and 22% (33) were operators of cars, trucks, RVs or vans. Information on the presence of restraints was provided for 92 of the reviewed deaths. Restraints were reportedly not used in 49 (61%) incidents in which a vehicle was known to be equipped with a restraint (80). The percentage could be considerably higher because teams could not determine whether restraints were used in 30 additional deaths. The remainder of deaths involved bicycles (6), all terrain vehicles (7), motor cycles (3), and pedestrian incidents (30). Of the 6 deaths of children riding bicycles, 5 children were not wearing helmets.

Figure 19. Motor Vehicle-Related Deaths by Age

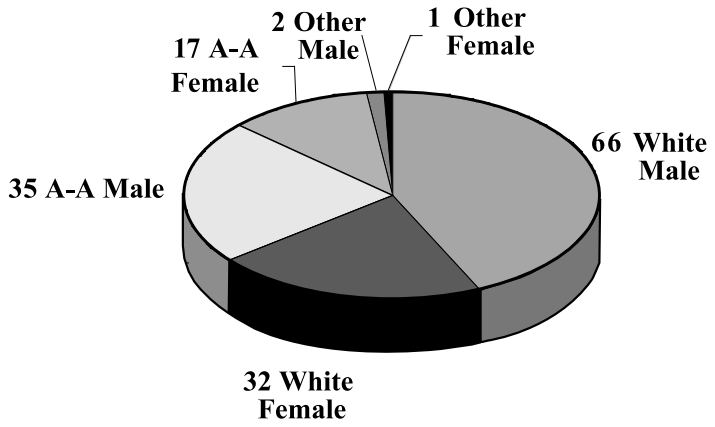


• Findings

- 44% of reviewed motor vehicle-related deaths occurred among teens ages 15-17
- As teens achieved legal driving age, the number of deaths increased as follows:

Age 15	18 deaths
Age 16	23 deaths
Age 17	26 deaths

Figure 20. Motor Vehicle-Related Deaths by Race and Gender

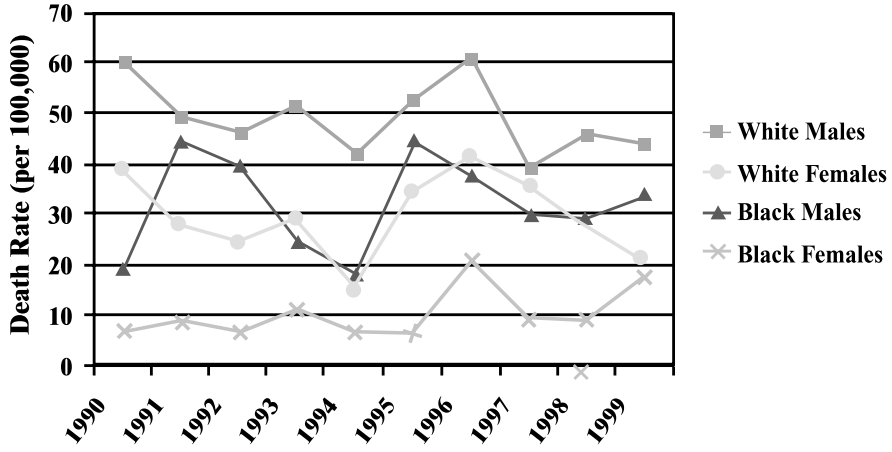


• Findings

- 64% (133) of deaths were white children
- 67% (103) of deaths were males

Motor Vehicle Trends

Figure 21. Motor Vehicle Fatality Rates per 100,000: Age 15-17, 1990-1999



• Findings

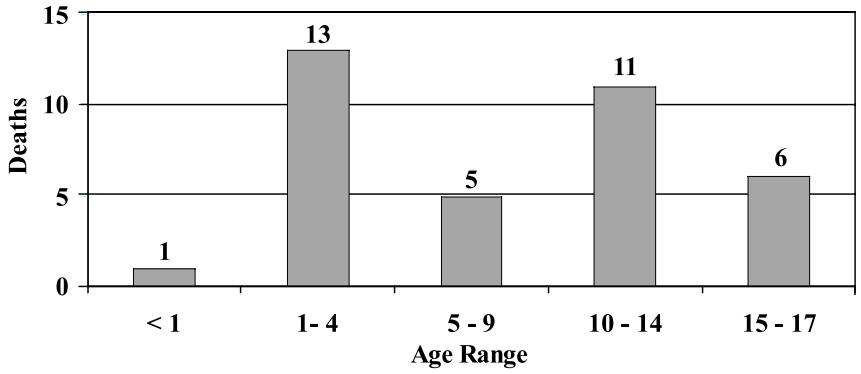
- The total number of MVA fatalities for 15-17 year olds increased slightly (from 95 to 99) from 1998 to 1999
- Motor vehicle crashes remain the leading cause of death among teens 15 to 17. All other accidental or violent deaths only total 74 deaths in this age group
- Among white teens, the rates decreased slightly for both genders; and among black teens, the rates increased slightly for both genders

Opportunities for Prevention

- Promote educational programs for parents and caregivers in settings such as hospitals, child care centers and health departments to teach proper installation and use of car seats and proper use of vehicle restraints
- Encourage communities to provide car seats to families with infants and young children who need financial assistance to purchase safe equipment
- Enforce child restraint laws and provide on-site education at the time a violation is found
- Support statewide availability of driver education programs
- Oppose changes to weaken the Teenage and Adult Driver Responsibility Act
- Continue to promote bicycle helmet use including education about proper fit and wearing position
- Encourage pedestrian safety campaigns

Child fatality review committees reviewed 36 drowning deaths of children under the age of 18. Death certificate data identified drowning as the cause of death for 53 children which was a 36% increase from 1998 (39 deaths). Of the 36 children whose deaths were reviewed, 16 died in pools, 16 in natural bodies of water, and 4 in bathtubs. Only 2 children were wearing flotation devices.

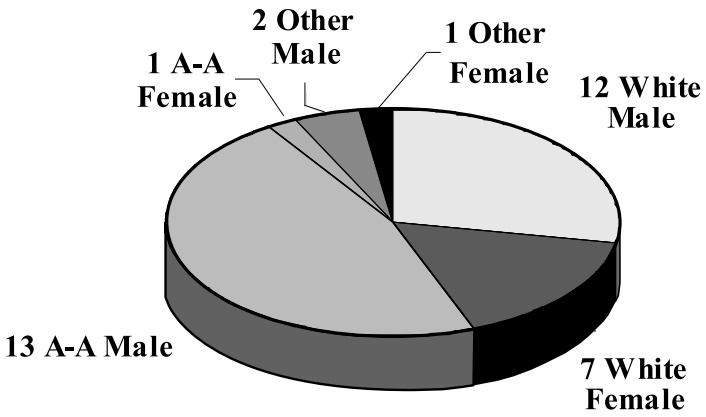
Figure 22. Deaths Due to Drowning by Age



• Finding

- 44% of drowning victims were children between the ages of 5 and 14

Figure 23. Drowning Deaths by Race and Gender

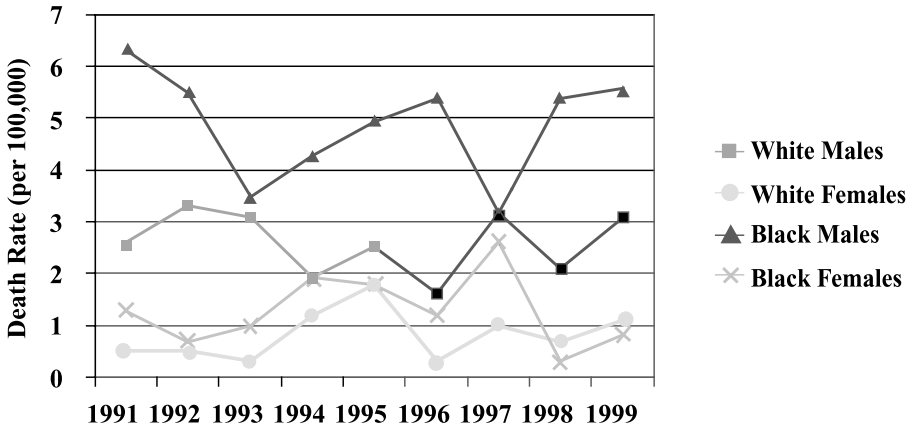


• Finding

- Three times as many drowning deaths occurred among males as females

Drowning Trends

Figure 24. Drowning Fatality Rates per 100,000: Ages < 18, 1990-1999



• Findings

- The total number of drowning deaths increased from 39 in 1998 to 53 in 1999. There were seven additional white male deaths in 1999, and slight increases in drowning deaths for all the other race/gender groups
- Total child drowning deaths have remained fairly constant over the decade, with an average of 43 per year. The annual numbers fluctuate, but there are no apparent trends. Black males have consistently had the highest rates

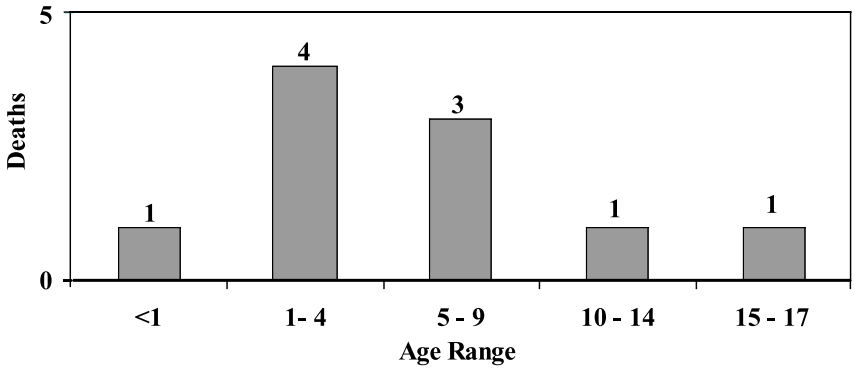
Opportunities for Prevention

- Increase public education efforts that teach water safety and skills, especially among school aged children
- Enact and enforce statewide ordinances related to fences and gates in public and private swimming pools
- Develop media messages about never leaving children unattended near water, including buckets and bathtubs

FIRE-RELATED DEATHS

Child Fatality Review teams reviewed 10 fire-related deaths in 1999. Death certificate data indicated a total of 10 fire-related deaths, which represents a 57% decrease from 1998 (23).

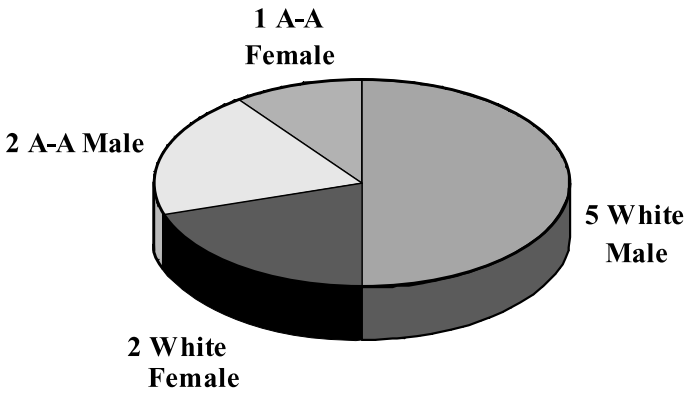
Figure 25. Deaths Due to Fire by Age



Findings

- Reviewed fire-related deaths decreased from 17 to 10 (41%)
- A majority of the victims of fire-related deaths (80%) were under the age of 10

Figure 26. Deaths Due to Fire by Race and Gender

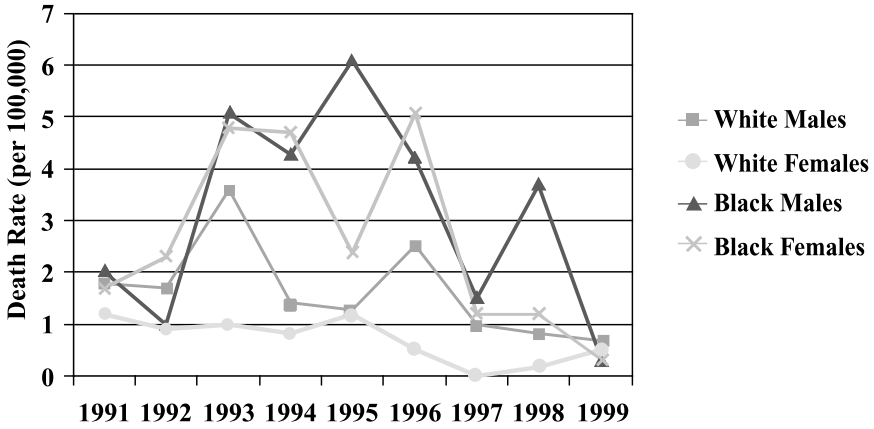


• Findings

- Fire-related deaths among whites was more than double the number for African Americans
- Fire-related deaths among males was more than double the number for females

Fire-Related Trends

Figure 27. Fire-Related Fatality Rates per 100,000 Ages < 18, 1990-1999



• Findings

- The total number of fire-related deaths decreased from 23 in 1998 to 10 in 1999. This decrease was due to a decrease in the number of black, male victims from 13 to 2
- Although 1999 had the lowest number of fire-related deaths for the decade, the average number of deaths for the past three years ('97-'99) was only 16. For the preceding seven years ('90-'96), there had been an average of 41 child deaths attributable to fire per year
- These numbers suggest a "real" improvement in the prevention of deaths due to fire, and not just statistical fluctuations

Opportunities for Prevention

- Continue and expand school fire safety programs that teach critical messages like "stop, drop and roll" and those that help families plan fire escape routes
- Continue and expand community programs to provide smoke detectors and batteries to families who can not afford them
- Promote public education about the importance of changing smoke detector batteries every six months

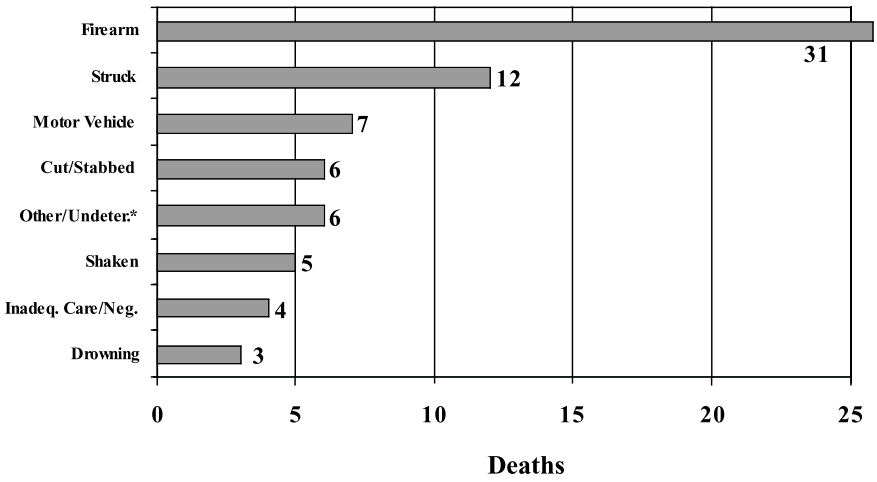
INTENTIONAL INJURY DEATHS

In 1999, child fatality review committees determined a total of 94 deaths (74 homicides and 20 suicides) to be the result of intentional injuries. Death certificate data also reported 94 deaths resulting from intentional injuries, but with some differences in manner (68 homicides and 26 suicides). The total number of reviewed deaths resulting from intentional injuries increased 15% compared to 1998 because of an increase in homicide deaths. Of the 114 child abuse and neglect related deaths, 44 were homicides.

HOMICIDE

Child fatality review teams reviewed 74 homicide deaths. Figure 31 presents the reviewed homicide deaths by manner of death.

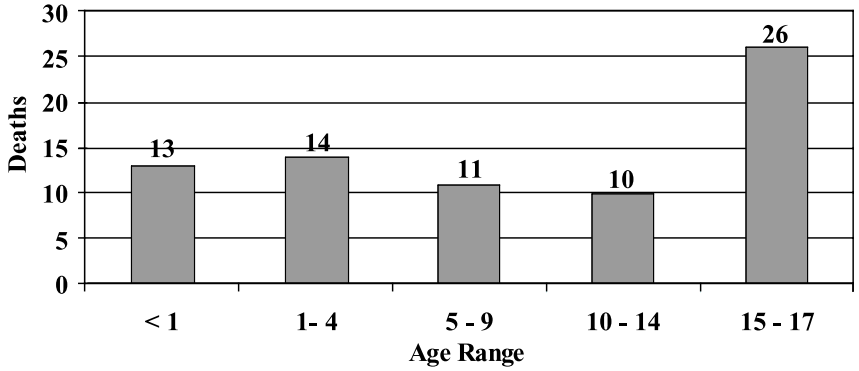
Figure 28. Reviewed Homicide Deaths by Circumstances of Death



• Findings

- Firearms were the cause of 42% (31) of homicides
- 20 deaths resulted from inflicted injuries that include being struck (12), stabbed (6), and thrown (2)
- 5 children were victims of Shaken Baby/Sudden Impact Syndrome

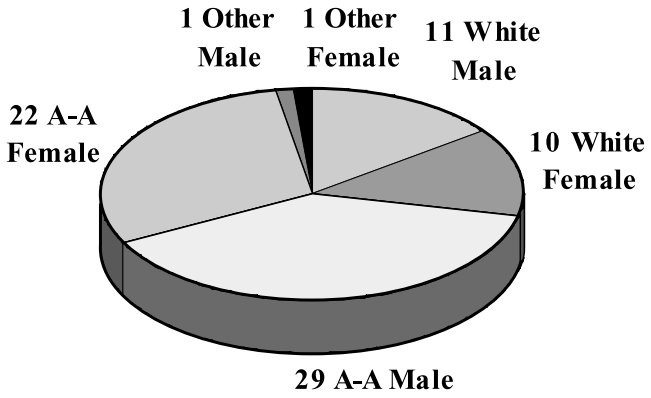
Figure 29. Reviewed Homicide Deaths by Age



• Findings

- Homicides among 15-17 year olds were 35% of all reviewed homicides
- 37% of homicide deaths were children less than 5 years of age

Figure 30. Reviewed Homicide Deaths by Race and Gender

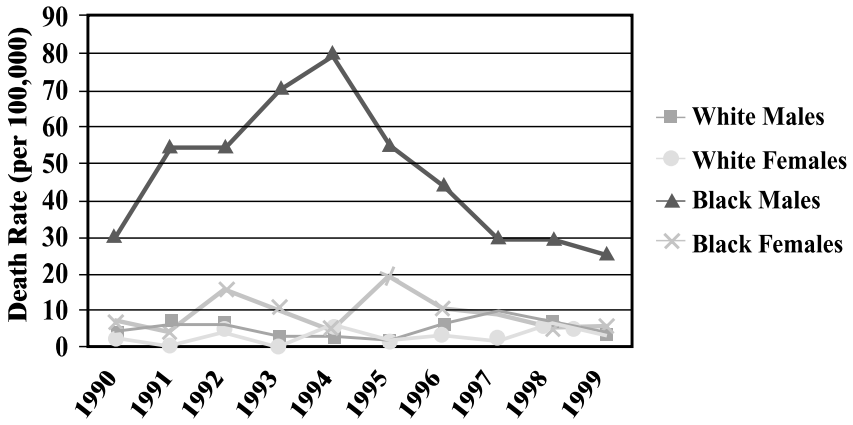


Findings

- 55% of homicide victims were male
- 69% of homicide victims were African-American
- 39% of homicide victims were African-American males

Homicide Trends

Figure 31. Death Rates for Teen Homicides per 100,000 Ages 15-17, 1990-1999



• Findings

- The total number of teen (15 to 17) homicides decreased slightly from 1998 (33 deaths in 1998 and 26 deaths in 1999)
- Black males continue to have a very disproportionate homicide rate - approximately five times the rate of any other race/gender group. Fifteen of the teen homicides in 1999 were black males, with the other three groups accounting for only eleven deaths. (18% of the population contributed 58% of the deaths.)

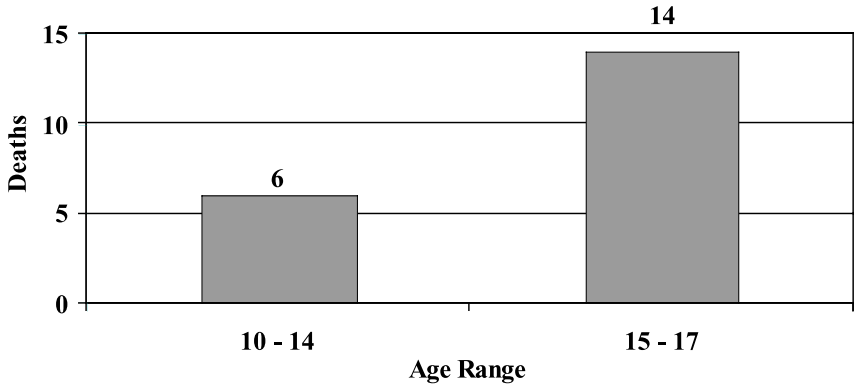
Opportunities for Prevention

- Promote school-based programs teaching conflict resolution, impulse control, anger management and empathy
- Increase the availability of community-based parenting education including positive discipline techniques
- Support legislation promoting responsible gun ownership including use of firearm safety locks and safe firearm storage

SUICIDE

In 1999, child fatality review committees reviewed 20 deaths of children who took their own lives. Death certificate data indicated a total of 26 suicide deaths. Firearms were used in 65% (13) of reviewed suicides. Six deaths resulted from strangulation (hanging), and 1 death from a motor vehicle incident. The following figures provide more information about suicides.

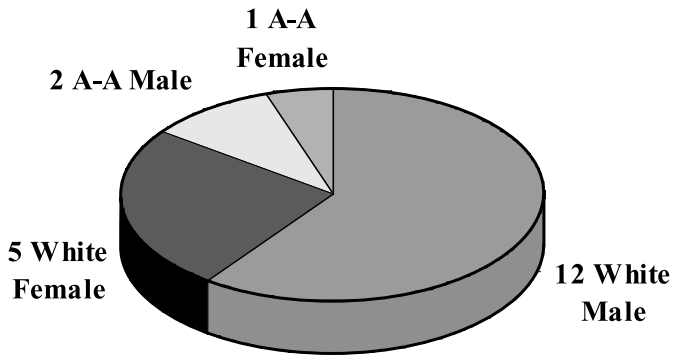
Figure 32. Suicide Deaths by Age



• Findings

- 70% of suicides occurred to teens 15-17
- The youngest suicide victim (12 years old) died of a gunshot wound

Figure 33. Suicide Deaths by Race and Gender

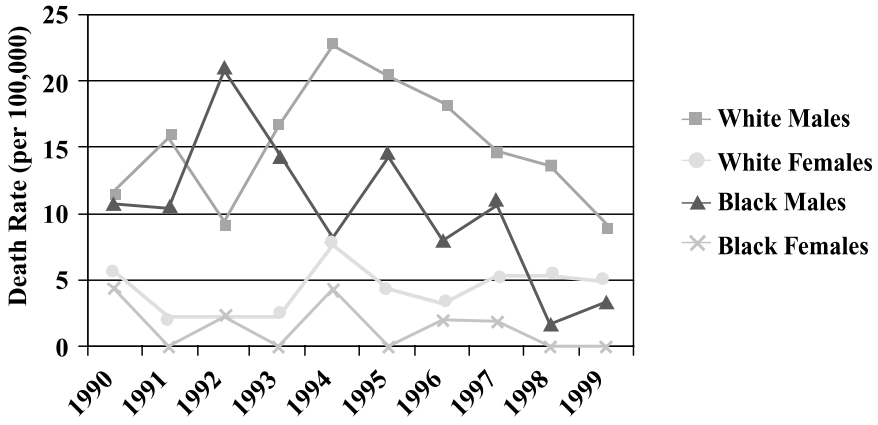


• Findings

- 85% of all suicide victims were white children
- 70% of suicide victims were males
- 60% of suicide victims were white males

Suicide Trends

Figure 34. Suicide Death Rates 1990-1999 per 100,000, Ages 15-17



• Findings

- Suicide in this age group remains predominantly a white male problem. In 1999, 10 of the 17 suicide victims (ages 15 to 17) were white males. This was down from 14 in 1998. Five of the remaining seven deaths were white females
- The average number of suicide deaths for the decade has been 25 per year, so the past two years (20 and 17, respectively) appear to show a slight decline

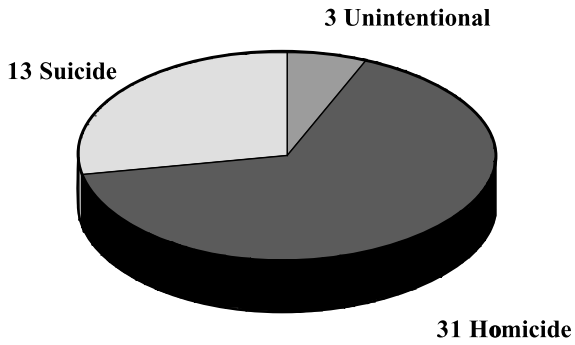
Opportunities for Prevention

- Increase community awareness of suicide warning signs
- Develop community intervention resources for children at risk for suicide
- Promote prompt action when warning signs are recognized
- Advocate for safe home storage of firearms

FIREARM DEATHS

Forty-seven of the deaths reviewed by child fatality review committees were caused by firearms. Firearm deaths include homicides, suicides and unintentional injuries. Death certificate data indicated a total of 51 deaths resulting from firearms. Child fatality review reports ask for information not available on death certificates including source of the firearm, type of firearm, who was using the firearm at the time of death and the age of the firearm handler. This information provides important guidance for prevention.

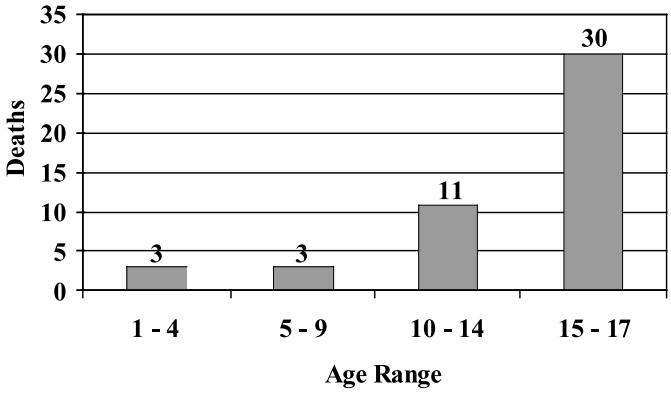
Figure 35. Firearm Deaths by Manner of Death



• Findings

- 66% of firearm deaths were homicides
- 6% were unintentional
- 28% were suicides

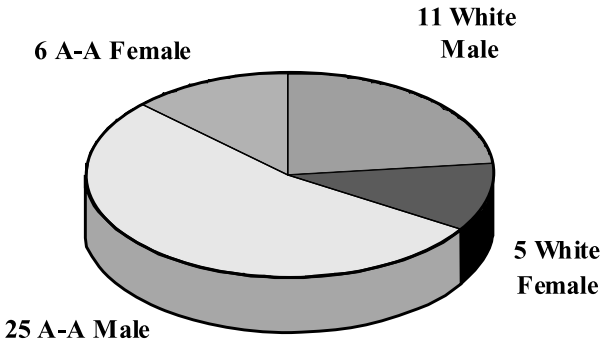
Figure 36. Firearm Deaths by Age



• Finding

- 64% of firearm deaths occurred to children ages 15-17

Figure 37. Firearm Deaths by Race and Gender



• Findings

* 66% of firearm victims were African-American

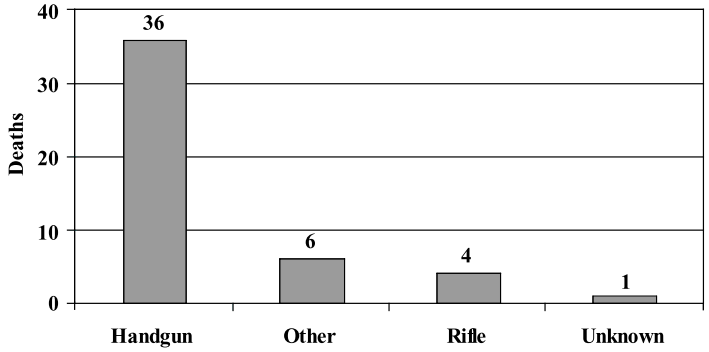
* 77% of firearm victims were male

Source of Firearm

- In 55% (26) of firearm related deaths, the firearm was obtained from someone the child knew (a parent, other relative, or acquaintance)
- Parents were the source of the firearm in 6 of the 13 suicides by firearm
- The source of the firearm was unknown in 32% (15) of reviewed deaths

Type of Firearm

Figure 38. Reviewed Firearm Deaths by Type of Firearm



• Findings

- 77% (36) of firearms were handguns compared to 66% in 1998
- Of the 20 reviewed suicide deaths, 65% (13) were committed with a firearm, and 9 of those 13 (69%) were handguns
- Of the 74 reviewed homicides, 38% (31) were committed with a firearm, and 26 of the 31 (84%) were handguns

Usage

- 83% (39) of the time the shooter was aiming at him/herself or at someone else
- 6 deaths were the result of the shooter "playing" with the firearm

Storage

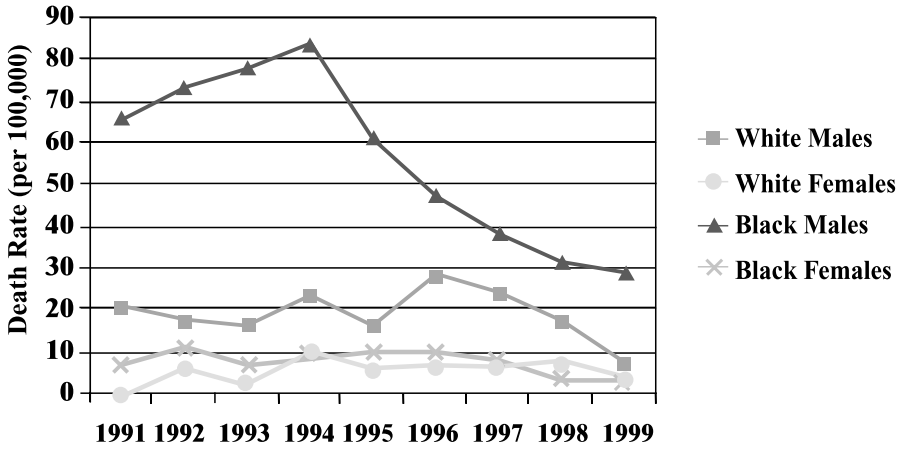
- In 28% (13) of the deaths, the firearm was not secured prior to the injury

Age of Handler

- The age varied from 7 years to 60 years
- The shooter was under the age of 16 in 100% of the unintentional deaths
- When the age of the handler was known, 53% of handlers were under the age of 18

Firearm Trends

Figure 39. Firearm Death Rates per 100,000, Ages 15-17, 1990-1999



• Findings

- There were sixteen fewer firearm-related deaths in 1999 than in 1998 (47 in 1998 versus 31 in 1999). Most of this decrease was due to a drop (from 18 to 8) in white male deaths
- The rates for both white and black males are at their lowest points in the decade

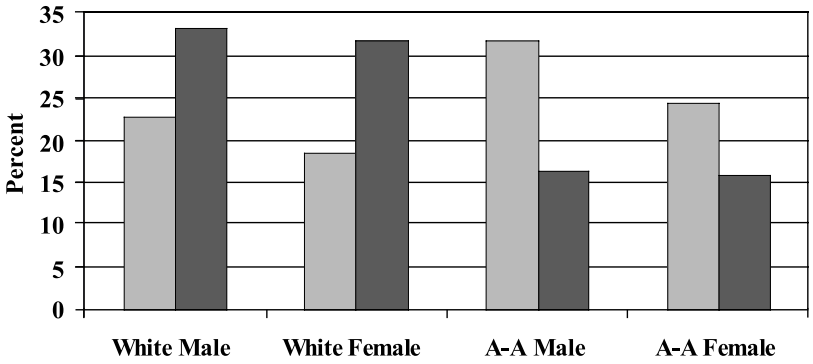
Opportunities for Prevention

- Promote risk reduction education for families who have firearms in the home
- Promote use of firearm safety devices
- Support efforts to limit minors' access to firearms

RACE, ETHNICITY AND DISPROPORTIONATE DEATHS

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. The terms "White", "African-American" (A-A) and "Other" are used to identify racial groups throughout the report. "Other" refers to children of Asian, Pacific Islander, or Native American origin. Death certificate data includes ethnicity information that can identify children of Hispanic origin. Sixty (60) of 63 deaths identified as Hispanic indicated the race as "White." One death identified as Hispanic indicated African-American as the race, and the remaining 2 indicated the race to be Asian.

Figure 40. Deaths to Children < 1 and Percent of Population in Georgia By Race and Gender



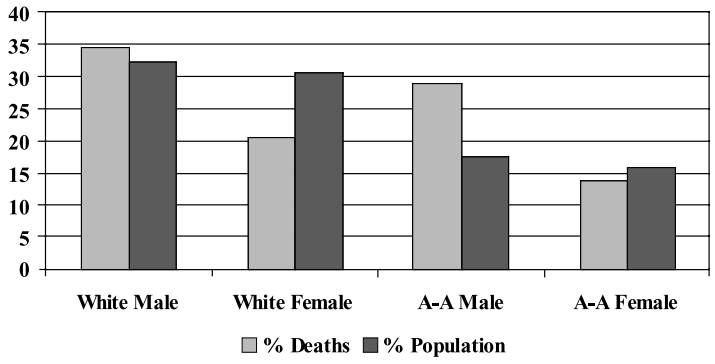
• Findings

- A disproportionate number of deaths occurred among African-American infants

	% of Deaths	% of Population
All A-A Infants	56.1	32.2
A-A Male Infants	31.7	16.4
A-A Female Infants	24.4	15.8

- The infant mortality rate for African-American infants (13.9 per 1,000 births) was more than double the rate for white infants (5.3 deaths per 1,000 births)

Figure 41. Deaths to Children 1-17 and Percent of Population in Georgia By Race and Gender



- A disproportionate number of deaths occurred among male children
- The percentage of deaths that occurred among African-American males was almost double the percent of the African American male population in this age group.

	% of Deaths	% of Population
All Males 1– 17	59.0	51.2
A-A Males 1– 17	31.7	16.4
White Males 1– 17	27.4	32.4

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols to determine how investigations of alleged child abuse and neglect are to be conducted and prosecuted. The written protocol also addresses treatment for victims, families, and perpetrators.

1993

Statutory amendments were adopted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Change the name of the Statewide Child Fatality Review Panel to the Statewide Child Abuse Prevention Panel and require the Panel to:
- Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
- Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
- Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases
- Monitor implementation of the State Child Abuse Prevention Plan

1996

The Statewide Child Abuse Prevention Panel was attached for administrative purposes to the Georgia Children's Trust Fund Commission and the Office of Child Fatality Review was established with a full-time director to administer the activities of the Panel.

1997

At the request of members of the General Assembly, an evaluation of the Child Fatality Review Process was conducted by researchers from the Emory University Center for Injury Control and the Georgia State University Applied Research Center. The evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly.

1998

Statutory amendments were adopted to:

- Identify agencies required to be represented on child fatality review teams
- Establish penalties for non-participation of mandated agencies
- Require that all child deaths be reported to coroner/medical examiner
- Establish time limits for notification of child deaths to the chair of the child fatality review team
- Require that the decision to accept cases for review be a joint decision between the coroner/medical examiner and the county child fatality review team chairperson

1999

An awareness of the need for more thorough, consistent child death scene investigations led to a pilot of child death investigation teams. Teams were developed in four judicial circuits representing 11 counties. Team members were identified as law enforcement, coroner or medical examiner, district attorney representative, and department of family and children services representative.

APPENDIX A

CRITERIA FOR CHILD DEATH REVIEWS

Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Teams

The death of a child under the age of 18 must be reviewed when the death is ***suspicious, unusual, or unexpected.*** Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

APPENDIX B.
CHILD FATALITY REVIEW TIMEFRAMES AND RESPONSIBILITIES

Any child who dies in the county, birth through age 17, will be reported to the coroner/medical examiner.

If child is resident of the county, **medical examiner or coroner will notify chairperson of child fatality review subcommittee in the child's county of residence within** 48 hours **of receiving report of child death (Code Section 19-15-3).**

If child is not resident of county, medical examiner or coroner of the county of death will notify the medical examiner or coroner in the county of the child's residence within **48 hours** of the death.

Within **7 days**, coroner/medical examiner in county of death will send coroner/medical examiner in county of residence a copy of Form 1 along with any other available documentation regarding the death.

Upon receipt, coroner/medical examiner in county of residence will follow outlined procedures.

Medical examiner or coroner reviews the findings regarding cause of death.

If cause of **death meets the criteria** for review pursuant Code Section 45-16-24, medical examiner or coroner will complete Form 1 and forward to the chair of the child fatality review subcommittee for review within **7 days** of child's death.

If cause of death does not meet the criteria for review pursuant to Code Section 45-16-24, the medical examiner/coroner will complete Sections A, B, and J of Form 1 and forward to the chair of the child fatality review subcommittee within **7 days**.

If chair believes death meets the criteria for review, chair will call subcommittee together.

If chair of Subcommittee agrees that death does not meet criteria for review, then chairperson signs Section J of Form 1 and forward to the State-wide Child Abuse Prevention Panel.

Subcommittee meets to review report and conduct investigation into the child death within **30 days** of receiving the report.

Subcommittee will complete its investigation within **20 days** after the first meeting following the receipt of the medical examiner or coroner's report.

Subcommittee transmits a copy of its report within **15 days** of completion to the Office of Child Fatality Review.

Send copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

APPENDIX C. Deaths, CFRs, and Abuse Summary, Georgia, 1999

C.1 All Infant / Child Deaths (Cause based on DC)

Cause of Death	White		Black		Other			Age Group			
	Male	Female	Male	Female	Male	Female	Total	Infant	1 to 4	5 to 14	15 to 17
Drowning	21	7	20	3	1	1	53	1	17	23	12
Fire / Burns	5	3	1	1	0	0	10	0	4	4	2
Poisoning	7	0	5	1	1	0	14	4	2	5	3
Suffocation	13	6	9	6	0	0	34	18	4	7	5
Vehicle Crashes	93	47	55	28	1	1	225	9	33	84	99
Other	13	4	7	2	1	0	27	4	4	10	9
Homicide	8	12	29	18	1	0	68	12	13	17	26
Suicide	16	7	2	1	0	0	26	0	0	9	17
SIDS (All)	33	18	36	26	1	2	116	116	0	0	0
Medical Causes	258	227	358	259	15	14	1,131	873	83	120	55
Total	**467**	**331**	**522**	**345**	**21**	**18**	**1,704**	**1,037**	**160**	**279**	**228**

C.2 All Reviewed Deaths (Cause based on CFR)

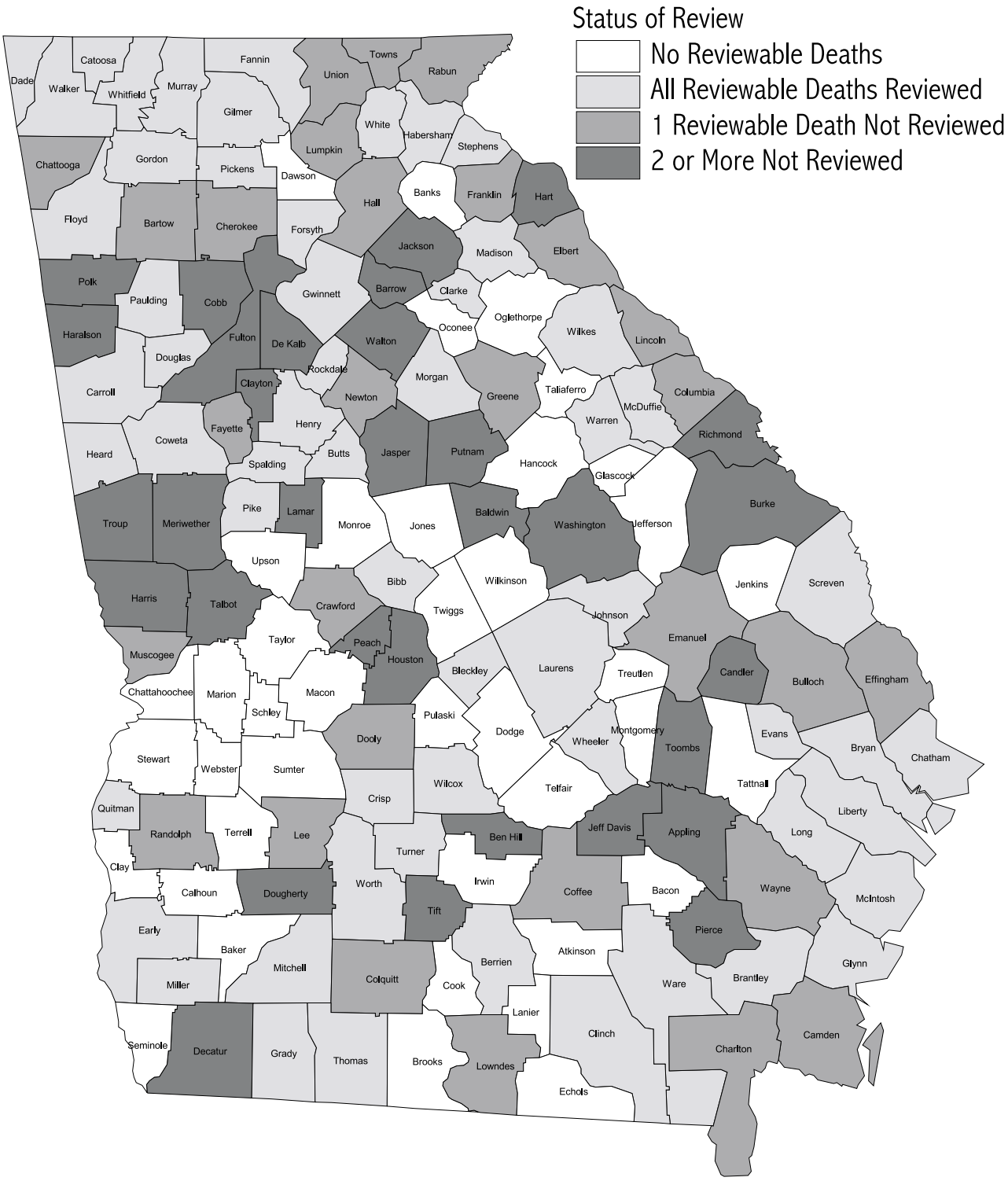
Cause of Death	White		Black		Other			Age Group			
	Male	Female	Male	Female	Male	Female	Total	Infant	1 to 4	5 to 14	15 to 17
Drowning	12	7	13	1	2	1	36	1	17	23	12
Fire / Burns	5	2	2	1	0	0	10	0	4	4	2
Poisoning	4	2	3	1	1	0	11	4	2	5	3
Suffocation	16	5	6	4	0	0	31	18	4	7	5
Vehicle Crashes	66	32	35	17	2	1	153	9	33	84	99
OtherAccidents	5	2	9	0	0	0	16	4	4	10	9
Homicide	8	12	29	22	1	0	68	12	13	17	26
Suicide	16	7	2	1	0	0	26	0	0	9	17
SIDS	33	18	32	20	1	3	100	116	19	26	13
Medical Causes	24	18	35	33	2	4	116	58	19	26	13
Unknown	3	0	1	1	0	0	5	4	1	0	0
Total	**185**	**100**	**167**	**101**	**9**	**10**	**572**	**203**	**81**	**152**	**136**

C.3 Reviewed Deaths with Abuse / Neglect Finding (Cause based on CFR)

Cause of Death	White		Black		Other			Age Group			
	Male	Female	Male	Female	Male	Female	Total	Infant	1 to 4	5 to 14	15 to 17
Drowning	2	1	3	0	0	1	7	1	5	2	0
Fire / Burns	3	1	0	0	0	0	4	1	3	0	0
Poisoning	1	0	0	0	1	0	2	1	1	0	0
Suffocation	3	1	9	6	0	0	7	7	0	0	0
Vehicle Crashes	6	3	9	2	1	0	21	4	7	10	0
Other Accidents	1	0	6	0	0	0	7	2	2	3	0
Homicide	2	7	16	17	1	1	44	13	12	14	5
Suicide	1	0	0	0	0	0	1	0	0	0	1
SIDS	2	2	3	0	0	0	7	7	0	0	0
Medical Causes	2	1	4	4	0	1	12	7	2	1	2
Unknown	2	0	0	0	0	0	2	2	0	0	0
Total	**25**	**16**	**43**	**24**	**3**	**3**	**114**	**44**	**32**	**30**	**8**

APPENDIX D

Distribution of Reviewable Deaths Not Reviewed by Georgia Counties



APPENDIX E

Appendix E presents county level data for the Child Fatality Review process in 1998. The data is presented for four age groups (infants less than one year old, children from one to four years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

Total Deaths:

The total number of deaths (all causes) for that age group. This number is based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia.

Eligible Deaths:

The number of SIDS, accidental, or violence related deaths (eligible deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 45-16-24 (see Figure 1, p. 8), SIDS deaths are explicitly required to be reviewed, and accidental/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

Eligible Deaths Reviewed:

The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "eligible" deaths.

Total Deaths Reviewed:

This is the total number of child deaths in 1998 for which a Child Fatality Review Report was submitted. It includes deaths due to medical causes (other than SIDS) in addition to those deaths which were identified as eligible for review. This is based on the county of residence from the death certificates, not the county submitting the report.

APPENDIX E. 1999 CHILD FATALITY REVIEWS, BY DEATH CERTIFICATE COUNTY OF RESIDENCE

	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
County	**Age: <1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**
Appling	2		4	2	8			4	2	6			3		3	2		3		5
Atkinson	2				2															
Bacon	1				1															
Baker																				
Baldwin	9		7		16	1		4		5			1		1					
Banks																		1		1
Barrow	1	2	3	1	7			3	1	4			1		1		1	1		2
Bartow	7	1	1	3	12	4		1	3	8	4		1	2	7	5		2	2	9
Ben Hill	1		1	2	4	1			1	2										
Berrien	1		1	1	3			1		1			1		1			1		1
Bibb	36	5	4	5	50						1	3	1	3	8	1	3	2	4	10
Bleckley	1				1	1				1	1				1	1				1
Brantley		1	1	1	3			1	1	2			1	1	2			1	1	2
Brooks	2		1		3															
Bryan	3	1		1	5						1	1		1	3					
Bulloch	13	1	2		16	3	1	2		6	3	1	1		5	4	1	1		6
Burke	4	1	1	2	8	1	1	1	1	4										
Butts	3	1	1		5	1	1			2	1	1			2	1	1			2
Calhoun	1		1		2															
Camden	4		2		6	1		1		2	1				1	1				1
Candler	2		2	2	6			1	1	2										
Carroll	11		2	9	22	3		2	6	11	3		2	6	11	4		1	6	11
Catoosa	3	1	3	1	8	2	1	2	1	6	2	1	2	1	6	2	1	2	1	6
Charlton	1		1	1	3			1		1										
Chatham	26	2	9	1	38	4		2	1	7	4		2	1	7	7	1	5	1	14
Chattahoochee																				
Chattooga	3	1		2	6	1			1	2	1				1	1				1
Cherokee	11	3	3	2	19	3	1	1	2	7	3	1	1	1	6	2	1	1	1	5
Clarke	16		3	3	22	2		1	3	6	2		1	3	6	2	1	2	3	8
Clay	2				2															
Clayton	31	4	3	6	44	5	2	1	4	12										
Clinch	2			1	3															
Cobb	56	6	15	10	87	10	2	13	8	33	9	2	12	8	31	13	3	12	7	35
Coffee	9	1		1	11															
Colquitt	13	2	1	5	21															
Columbia	7		2	1	10			1	1	2				1	1				1	1
Cook	5				5															
Coweta	11		3	1	15	1		2	1	4	1		2	1	4	1		3	1	5
Crawford			1		1			1		1										
Crisp	4	1			5		1			1		1			1	1	1			2

APPENDIX E. 1999 CHILD FATALITY REVIEWS, BY DEATH CERTIFICATE COUNTY OF RESIDENCE

	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
County	**Age: <1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**
Dade				1	1				1	1				1	1				1	1
Dawson	1				1															
Decatur	7		3		10	2		3		5										
Dekalb	84	13	30	18	145	15	3	12	13	43	14	3	10	11	38	13	5	14	12	44
Dodge	1	1			2															
Dooly	2			1	3				1	1										
Dougherty	12	3	3	1	19	2	2		1	5	1	1			2	1	2			3
Douglas	8	1	2	6	17	1		1	5	7	1		1	5	7	2		1	4	7
Early	3	1	1		5		1			1		1			1		1	1		2
Echols	1				1															
Effingham	2		3	1	6			2	1	3			1	1	2			1	1	2
Elbert	1		1	2	4				2	2				1	1				1	1
Emanuel	7			3	10				2	2				1	1				1	1
Evans	1		1		2			1		1			1		1			1		1
Fannin	3		1	1	5				1	1				1	1	1			1	2
Fayette	3	3	1	5	12	1	2		3	6	1	2		2	5	1	3	1	4	9
Floyd	6	2	3	1	12		1	3		4		1	3		4	1	1	3	1	6
Forsyth	7	2	4	2	15	1		4	2	7	1		4	2	7	2		4	2	6
Franklin	2			1	3				1	1						1			1	2
Fulton	117	12	33	22	184	23	7	23	19	72	21	5	20	19	65	34	6	21	20	81
Gilmer		2	1	1	4		2	1	1	4		2	1	1	4		2	1	1	4
Glascock																				
Glynn	7		1	4	12	3		1	2	6	3		1	2	6	3		1	4	8
Gordon	7	1	3	1	12		1	2	1	4		1	2	1	4	2	2	2	1	7
Grady	7	2	2	4	15	2		2	4	8	2		2	4	8	4	1	2	4	11
Greene	4		1	1	6	1		1		2			1		1			1		1
Gwinnett	64	15	11	6	96	10	10	6	4	30	10	10	6	4	30	10	10	7	4	31
Habersham	6	1	3		10	2		3		5	2		3		5	2		3		5
Hall	16	4	2	2	24	2		1	2	5	1		1	2	4	3	1	1	2	7
Hancock	1				1															
Haralson		3	1	2	6		3		1	4										
Harris	2			4	6				4	4										
Hart	4	1		2	7		1		2	3										
Heard	4		1		5	2				2	2				2	2				2
Henry	10	4	4		18		2	3		5		2	3		5		3	3		6
Houston	14	2	3	1	20	1	1		1	3										
Irwin																				
Jackson	6		1	1	8	1		1	1	3								1		1
Jasper	4				4	2				2										
Jeff Davis			1	2	3			1	2	3										

APPENDIX E. 1999 CHILD FATALITY REVIEWS, BY DEATH CERTIFICATE COUNTY OF RESIDENCE

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
	Age: <1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Jefferson	3		1		4															
Jenkins	1		1		2															
Johnson	3	1	1		5			1		1			1		1		1	1		2
Jones	3				3															
Lamar	2		1	2	5	1		1	2	4										
Lanier	1		1		2											2				2
Laurens	9	1	4	3	17	1	1	3	1	6	1	1	3	1	6	8	1	4	3	16
Lee				2	2				1	1										
Liberty	18	1	2	3	24	3	1	1	2	7	3	1	1	2	7	2	2	2	3	9
Lincoln	1		2	1	4			1		1										
Long	1		1		2	1				1	1				1	1				1
Lowndes	16	6	1	1	24	3	2	1		6	3	2	1		6	5	4	3	1	13
Lumpkin		1		1	2				1	1						1				1
Macon	2				2															
Madison	3	1	1	2	7	2	1	1	2	6	2	1	1	2	6	2	1	1	2	6
Marion																				
Mcduffie	3		2	1	6			2	1	3			2	1	3			2	1	3
Mcintosh	3	1			4		1			1		1			1		1			1
Meriwether	4	1		2	7	1	1		2	4										
Miller	1				1	1				1	1				1	1				1
Mitchell	1			2	3				1	1				1	1				1	1
Monroe	3				3															
Montgomery																1				1
Morgan	1	1	4	1	7			2	1	3			2	1	3			2	1	3
Murray	2		1		3	1		1		2	1		1		2	1		1		2
Muscogee	48	2	7	6	63	9	1	4	4	18	8	1	4	4	17	12	2	3	5	22
Newton	4	5	2	1	12		2	2	1	5		2	2		4		2	2		4
Oconee	4				4															
Oglethorpe																				
Paulding	3	1	5	4	13	1		2	4	7	1		2	4	7	1		4	4	9
Peach	4		1		5	1		1		2										
Pickens	5			1	6	1			1	2	1			1	2	3			1	4
Pierce	3		1	1	5	1		1	1	3										
Pike				4	4				3	3				3	3				4	4
Polk	4	2	1		7		2	1		3										
Pulaski																				
Putnam	3	1	1		5		1	1		2										
Quitman	1			1	2				1	1				1	1				1	1
Rabun	1				1	1				1										
Randolph	5			1	6				1	1										

APPENDIX E. 1999 CHILD FATALITY REVIEWS, BY DEATH CERTIFICATE COUNTY OF RESIDENCE

	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
County	**Age: <1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**	**<1**	**1-4**	**5-14**	**15-17**	**Total**
Richmond	31	3	8	5	47	2	3	1	2	8	1				1	1				1
Rockdale	4		2	2	8	1			2	3	1			2	3	2			2	4
Schley	1				1															
Screven	4	1	1	1	7		1	1		2		1	1		2	1	1	1		3
Seminole	3			1	4															
Spalding	11	3	1		15			1		1			1		1	3		1		4
Stephens	1	1	1	1	4				1	1				1	1			1		1
Stewart		1			1															
Sumter	3				3											1				1
Talbot	1			1	2	1			1	2										
Taliaferro	1				1															
Tattnall	2			1	3															
Taylor	1				1															
Telfair	1		1		2															
Terrell	3				3															
Thomas	9	3		1	13		3		1	4		3		1	4	1	3		1	5
Tift	6	2			8	1	1			2										
Toombs	7		1	2	10	2		1	2	5	1				1					
Towns	1			2	3	1			2	3	1			1	2	1			1	2
Treutlen																				
Troup	6	3	3	3	15	1	1	2	2	6	1	1			2	1	2	4		7
Turner	2			1	3	1			1	2	1			1	2	1			1	2
Twiggs	2		1		3											2		1		3
Union	1			1	2				1	1										
Upson	2			1	3															
Walker	2		2	2	6			1	1	2			1	1	2					
Walton	6	1	4	1	12	2		2		4	2				2	3				3
Ware	3	1	3		7	2		2		4	2		2		4	2	1	2		5
Warren	2	1	1		4		1			1		1			1		1	1		2
Washington	3	1	1		5	1	1	1		3										
Wayne	4	2	2		8		1			1										
Webster	1		1		2															
Wheeler		2	1	1	4			1	1	2			1	1	2		2	2	1	5
White	3			1	4	1			1	2				1	1					
Whitfield	8	1	2		11		1			1		1			1	2	1	2		5
Wilcox	3				3	2				2	2				2	1				1
Wilkes	3	2	1		6		1	1		2		1	1		2		1	1		2
Wilkinson	1				1															
Worth	1		2		3			1		1			1		1			1		1
Totals	**1,037**	**160**	**279**	**228**	**1,704**	**163**	**78**	**159**	**173**	**573**	**135**	**57**	**121**	**124**	**437**	**203**	**81**	**152**	**136**	**572**

APPENDIX F.
DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

A-A
African-American

Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review teams.

Child Fatality Review Team
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, and law enforcement.

Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.

Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.

Medical Cause
Refers to death resulting from a natural cause other than SIDS.

Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.

"Other" as Category of Death
Includes deaths from suffocation, choking, poisoning, and falls (unless otherwise indicated).

Perpetrator
Person(s) who committed an act that resulted in the death of a child .

Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

Reviewed Death
Death which has been reviewed by a local child fatality review team and a completed Child Fatality Review Report has been submitted to the Statewide Child Abuse Prevention Panel.

Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

Statewide Child Abuse Prevention Panel
An appointed body of 15 representatives that oversees the county child fatality review process, reports to he governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered as a "medical" cause.

Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.